KEVZARA connect® **Enrollment Form**

Prescription Information and KevzaraConnect® Patient Enrollment Form

Complete and fax pages 1-4 to KevzaraConnect® at 1-844-538-8960.

For additional assistance, call us at 1-844-KEVZARA (1-844-538-9272), Option 1, M-F 8 AM-9 PM ET

KEVZARA® (sarilumab)

Please see Indication and Important Safety Information on pages 5-7. Click here for Full Prescribing Information including Boxed WARNING.

SECTION 1 – Patient Information

Patient (First, MI, Last) ____ DOB (mm/dd/yyyy) ____ Gender ☐ M ☐ F

Street Address ____

City ____ State ____ ZIP Code ____

Caregiver ____ Caregiver Phone ____

Preferred Patient Language (if not English) ____

Preferred Phone ____ Best Hours to Call ____

Voice Mail Message Method ☐ Preferred Phone ☐ No Message

Text Message ☐ Preferred Phone ☐ No Message

☐ By checking this box, I indicate that I have read the Text Messaging Consent in Section 7 and expressly consent to receive text messages by or on behalf of the Program.

Email ____

PATIENT AUTHORIZATION

I have read and agree to the Patient Certifications included in section 7.

Sign ____ **Patient Signature/Legal Representative*** ____ Date (mm/dd/yyyy)

*Relationship to Patient ____

I have read and agree to the Patient Authorization to Use and Disclose Health Information included in Section 8.

Sign ____ **Patient Signature/Legal Representative*** ____ Date (mm/dd/yyyy)

*Relationship to Patient ____

SECTION 2 – Insurance Information (Please attach copies of front and back of medical and prescription cards.)

☐ **CHECK IF PATIENT DOES NOT HAVE INSURANCE (Please see section 6 for Patient Assistance Program eligibility.)**

Primary Medical Insurance ____ Insurance Phone ____

Policy ID Number ____ Group Number ____

Policy Holder Name (First, Last) ____ DOB (mm/dd/yyyy) ____

Relationship to Patient ____

Primary Prescription Drug Insurance ☐ **Secondary Insurance card attached**

Primary Prescription Drug Insurance Name ____

Insurance Phone ____

Policy ID Number ____ Group Number ____

Rx BIN Number ____ Rx PCN Number ____

SECTION 3 – Prescriber Information

Prescriber Name (First, MI, Last) ____

Prescriber NPI # ____ Group Tax ID # ____

Practice Name ____

Address ____

Phone ____ Fax ____

Specialty ____ Title ____

State License # ____

Office Contact ____ Office Contact Email ____

City ____ State ____ ZIP Code ____

Office Email ____

SECTION 4 – Clinical and Diagnosis Information (Please attach any clinical or office notes relevant to therapy.)

Primary ICD-10 Diagnosis Code ____

Other ICD-10 Diagnosis Code (please specify) ____

TB/PPD Test Date ____ ☐ POS ☐ NEG

Allergies ____

Current Medications ____

Current/Prior Failed RA Medication(s) Treatment		Length (mm/yyyy) – (mm/yyyy)	Reason for Discontinuation (if applicable)	Current/Prior Failed RA Medication(s) Treatment		Length (mm/yyyy) – (mm/yyyy)	Reason for Discontinuation (if applicable)
☐ methotrexate	☐ Current ☐ Prior ☐ Failed	–		☐ XELJANZ® (tofacitinib)	☐ Current ☐ Prior ☐ Failed	–	
☐ ENBREL® (etanercept)	☐ Current ☐ Prior ☐ Failed	–		☐ SIMPONI®/ SIMPONI ARIA® (golimumab)	☐ Current ☐ Prior ☐ Failed	–	
☐ HUMIRA® (adalimumab)	☐ Current ☐ Prior ☐ Failed	–					
☐ ORENCIA® (abatacept)	☐ Current ☐ Prior ☐ Failed	–		☐ ACTEMRA® (tocilizumab)	☐ Current ☐ Prior ☐ Failed	–	
☐ REMICADE® (infliximab)	☐ Current ☐ Prior ☐ Failed	–		☐ RITUXAN® (rituximab)	☐ Current ☐ Prior ☐ Failed	–	
☐ CIMZIA® (certolizumab)	☐ Current ☐ Prior ☐ Failed	–		☐ Other	☐ Current ☐ Prior ☐ Failed	–	

SECTION 5 – Prescription Information

My Preferred Specialty Pharmacy Name ____ Phone ____ Fax ____

☐ I have already sent this prescription to the specialty pharmacy above. By checking this box, I acknowledge this pharmacy's role in seeking to secure coverage on the patient's behalf.

Specialty Pharmacy Prescription for KEVZARA® (sarilumab)

☐ **KEVZARA Injection: 200 mg/1.14 mL in a single dose pre-filled syringe, Package of 2**

☐ **KEVZARA Injection: 150 mg/1.14 mL in a single dose pre-filled syringe, Package of 2**

Quantity ____

Refills # ____

Directions for use ____

My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate, and that therapy with KEVZARA is medically necessary. I understand that my patient's information provided to Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (the "Alliance"), is for the use of KevzaraConnect® solely to verify my patient's insurance coverage, to assess, if applicable, my patient's eligibility for patient assistance and other support programs, and to otherwise administer KEVZARA for the patient. I request that KevzaraConnect® conduct a benefit investigation for my patient and authorize KevzaraConnect® to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan; provided that if this prescription is not so designated, KevzaraConnect® is authorized to transmit this prescription to a network pharmacy it selects, or to the pharmacy otherwise indicated. I consent to KevzaraConnect® contacting me by fax, mail, or email to provide additional information about KEVZARA injection or KevzaraConnect®, and that KevzaraConnect® may revise, change, or terminate any program services at any time without notice to me.

If you are a New York prescriber, please use an original New York State prescription form. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Sign ____ **Prescriber Signature** (no stamps) (Dispense as Written) ____ Date (mm/dd/yyyy)

Prescriber Signature (substitution permissible) ____ Date (mm/dd/yyyy)

FOR KEVZARA QUICK START PROGRAM ONLY REQUESTS, COMPLETE THE KEVZARA QUICK START PROGRAM PRESCRIPTION ONLY

KEVZARA QUICK START PROGRAM PRESCRIPTION

(FOR USE BY KEVZARA QUICK START PROGRAM SPECIALTY PHARMACY ONLY)

☐ **KEVZARA Injection: 200 mg/1.14 mL in a single dose pre-filled syringe, Package of 2**

☐ **KEVZARA Injection: 150 mg/1.14 mL in a single dose pre-filled syringe, Package of 2**

Quantity ____ **Refills #** ____

Directions for use ____

I authorize for my patient one or more months of temporary shipments of KEVZARA during a benefits determination delay or during the appeals process after an initial coverage denial for KEVZARA by the patient's insurer. I authorize KevzaraConnect® to forward this prescription to the pharmacy dispensing the KEVZARA Quick Start Program product to the patient named herein.

If you are a New York prescriber, please use an original New York State prescription form. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Sign ____ **Prescriber Signature** (no stamps) (Dispense as Written) ____ Date (mm/dd/yyyy)

Prescriber Signature (substitution permissible) ____ Date (mm/dd/yyyy)

Please see Indication and Important Safety Information on pages 5-7. Click here for Full Prescribing Information including Boxed WARNING.

Patient Name ____________________ **Prescriber Name** ______________________ **NPI #** ____________________

SECTION 6 – Household Income

(Only required if requesting KevzaraConnect® patient assistance for uninsured patients or for patients who lack pharmacy benefit coverage)

How many people live in your household? ______________________

What is your total annual household income?* ___________________

*Salary/wages, Social Security income, unemployment insurance benefits, disability income, any other income for the household.

To qualify for the KevzaraConnect® Patient Assistance Program, I understand that I must not have confirmed insurance coverage for KEVZARA and I must meet certain income and other eligibility requirements. KevzaraConnect® may ask for proof of income at any time for the purpose of audit/verification. If requested, I agree to provide proof of income within thirty (30) days of the request.

Continuation in the program is conditioned upon timely verification of income. In addition, I agree to notify KevzaraConnect® if my insurance situation changes.

Complete and fax pages 1-4 to KevzaraConnect® at 1-844-538-8960.

SECTION 7 – Patient Certifications

(Please read the following carefully, then date and sign where indicated in Section 1 of page 1)

I am enrolling in KevzaraConnect® (the "Program") and authorize Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together the "Alliance") to provide me services under the Program, as described in the Program Enrollment Form and as may be added in the future. Such services include medication and adherence communications and support, medication dispensing support, coverage and financial assistance support, disease and medication education, injection training and other support services (the "Services").

I agree to my enrollment in the KevzaraConnect® Copay Card Program if confirmed as eligible, understand that Copay Card information will be sent to the designated specialty pharmacy along with my prescription, and any assistance with my applicable cost-sharing or co-payment for KEVZARA (sarilumab) injection will be made in accordance with the Program terms and conditions.

If I am completing Section 6, I confirm my agreement with the conditions set forth in Section 6, and certify that my household income is true and accurate to the best of my knowledge.I authorize the Alliance to contact me by mail, telephone, or email, or, if I indicate my agreement and consent below, by text*, with information about the Program, rheumatoid arthritis (RA) and products, promotions, services and research studies, and to ask my opinion about such information and topics, including market research and disease-related surveys. I further authorize the Alliance to de-identify my health information and use it in performing research including linkage with other de-identified information the Alliance receives from other sources, education, business analytics, marketing studies or for other commercial purposes. I understand that members of the Alliance may share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the Services or to send the communications listed above (the "Communications"). I understand and agree that the Alliance may use my health information for these purposes and may share my health information with my doctors, specialty pharmacies, and insurers.

I understand that I do not have to enroll in the Program or receive the Communications, and that I can still receive KEVZARA (sarilumab) injection, as prescribed by my physician. I may opt out of receiving Communications, individual support services offered by the Program, including the KEVZARA Patient Support Copay Card, or opt out of the Program entirely at any time by notifying a Program representative by telephone at 1-844-KEVZARA (844-538-9272), Option 1, or by sending a letter to KevzaraConnect®, 1800 Innovation Point Fort Mill, SC 29715. I also understand that the Services may be revised, changed, or terminated at any time.

Text Messaging Consent:

*I acknowledge that by checking the Text Messaging Consent box on page 1, I expressly consent to receive text messages from or on behalf of the Program at the mobile telephone number(s) that I provide.

I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify the Alliance promptly if any of my number(s) change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out from future text messages at any time by texting STOP to [#] from my mobile phone, and that I can get help for text messages by texting HELP to [#]. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. I understand that my consent is not required as a condition of purchasing any goods or services from Regeneron Pharmaceuticals, Inc., Sanofi US, or their affiliates. Message and data rates may apply.

You may keep a copy of this form for your records.

Complete and fax pages 1-4 to KevzaraConnect® at 1-844-538-8960.

SECTION 8 – Patient Authorization To Use And Disclose Health Information

(Please read the following carefully, then date and sign where indicated in section 1 of page 1)

I authorize my healthcare providers and staff, my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any specialty pharmacies that dispense my medication to disclose to Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (together, the "Alliance") health information about me, including information related to my medical condition and treatment, health insurance coverage and claims, prescription (including fill/refill information), and referral to and enrollment in the Program ("My Information") for the purposes of enrolling me in and providing certain services, including

- to determine if I am eligible to participate in KevzaraConnect® coverage assistance programs, patient assistance programs or other support programs (the "Program")
- to investigate my health insurance coverage for KEVZARA injection
- to obtain prior authorization for coverage
- to assist with appeals of denied claims for coverage
- for the operation and administration of the Program
- to refer me to, or to determine my eligibility for other programs, foundations or alternative sources of funding or coverage that may be available to provide assistance to me with the costs of my medication

I understand and agree that my healthcare providers, Health Insurers, and specialty pharmacy(ies) may receive remuneration from the Alliance in exchange for disclosing My Information to the Alliance and/or for providing me with support services in connection with the Program.

Once My Information has been disclosed to the Alliance, I understand that federal privacy laws may no longer protect it from further disclosure. However, the Alliance agrees to protect My Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise allowed by law.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits or Alliance medications. However, if I do not sign this Authorization, I understand that I will not be able to participate in the Program.

I understand that this Authorization expires 18 months from the date support is last provided under the Program, subject to applicable law, unless and until I withdraw (take back) this Authorization before then. Further, I understand that I may withdraw this Authorization at any time by mailing or faxing a written request to KevzaraConnect® at 1800 Innovation Point, Fort Mill, SC 29715; Fax: 1-844-538-8960. Withdrawal of this Authorization will end my participation in the Program and will not affect any disclosure of My Information based on this Authorization made before my request is received and processed by my healthcare providers and staff, my Health Insurers and specialty pharmacy(ies).

I understand that I may request a copy of this Authorization.

Complete and fax pages 1-4 to KevzaraConnect® at 1-844-538-8960.

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